**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

PO BOX 700311
SAN ANTONIO TX 78270

COMBINED CHIROPRACTIC SERVICES & REHABILITATION, INC.

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Tracking Number**

M4-12-2446-01

**MFDR Date Received**

MARCH 26, 2012

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary:** "Medical Necessity."

**Amount in Dispute:** $2,165.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "Texas Mutual maintains its position as communicated to the requestor through its Explanation of Benefits forms. No payment is due for the nerve conduction and emg studies of 3/11/11."

**Response Submitted by:** Texas Mutual Insurance Co., 6210 East Hwy. 290, Austin, TX 78723-1098

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 11, 2011 | CPT Code 95900-59 (6) - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, without F-wave study | $690.00 | $0.00 |
| | CPT Code 95903-59 (4) - Nerve conduction, amplitude and latency/velocity study, each nerve; motor, with F-wave study | $460.00 | $0.00 |
| | CPT Code 95904-59 (6) - Nerve conduction, amplitude and latency/velocity study, each nerve; sensory | $690.00 | $0.00 |
| | CPT Code 95861 - Needle electromyography; 2 extremities with or without related paraspinal areas | $250.00 | $0.00 |
| | HCPCS Code A4556 (6) - Electrodes (e.g., apnea monitor), per pair | $30.00 | $0.00 |
| | HCPCS Code A4215 - Needle, sterile, any size, each | $5.00 | $0.00 |
| | HCPCS Code A4558 - Conductive gel or paste, for use with electrical device (e.g., TENS, NMES), per oz | $5.00 | $0.00 |
| March 11, 2011 | CPT Code 99211-25 - Office or other outpatient visit for the evaluation and management of an established | $35.00 | $0.00 |

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|---|---|---|---|
| | patient, that may not require the presence of a physician. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services. | | |
| TOTAL | | $2,165.00 | $0.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. 28 Texas Administrative Code §134.600, effective May 2, 2006, requires preauthorization for specific treatments and services.
4. 28 Texas Administrative Code §133.20, effective January 29, 2009, sets out the procedure for submitting medical bills.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated May 19, 2011
   - 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - CAC-W1-Workers' compensation state fee schedule adjustment.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code).
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 783-Comparison studies of non-compensable side are not reimbursed. Only allowed if compensable injury affects both extremities.
   - 857-Modifier-25 billed. Documentation does not support a significant, separately identifiable E&M service.
   - 762-Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.
   - 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.

   Explanation of benefits dated February 21, 2012
   - 732-Accurate coding is essential for reimbursement. CPT and/or modifier billed incorrectly. Services are not reimbursable as billed.
   - CAC-4-The procedure code is inconsistent with the modifier used or a required modifier is missing.
   - CAC-B18-This procedure code and modifier were invalid on the date of service.
   - CAC-W1-Workers' compensation state fee schedule adjustment.
   - CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code).
   - CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - CAC-197-Precertification/authorization/notification absent.
   - CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - 217-The value of this procedure is included in the value of another procedure performed on this date.
   - 225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
   - 762-Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules.

- 783-Comparison studies of non-compensable side are not reimbursed. Only allowed if compensable injury affects both extremities.
- 857-Modifier-25 billed. Documentation does not support a significant, separately identifiable E&M service.
- 891-No additional payment after reconsideration.
- 892-Denied in accordance with DWC rules and/or medical fee guideline including current CPT code descriptions/instructions.
- 893-This code is invalid or not covered or has been deleted.

**Issues**

1. Did the nerve studies require preauthorization?
2. Does the documentation support the level of service billed for CPT codes 95900, 95903, 95904, 95861?
3. Are HCPCS codes A4556, A4215 and A4558 included in another service/procedure billed on March 11, 2011?
4. Does the documentation support a separate identifiable Evaluation and Management service? Is the requestor entitled to reimbursement for CPT code 99211-25?

**Findings**

1. The respondent denied reimbursement for the disputed services, CPT codes 95900, 95903, 95904, and 95861, based upon reason code "762-Denied in accordance with 134.600(p)(12) treatment/service in excess of DWC treatment guidelines (ODG) per disability management rules".

   28 Texas Administrative Code § 134.600(p)(12) states "Non-emergency health care requiring preauthorization includes: treatments and services that exceed or are not addressed by the Commissioner's adopted treatment guidelines or protocols and are not contained in a treatment plan preauthorized by the carrier."

   Dr. Wolinsky wrote that "Patient is suffering with ongoing subjective complaints of neck pain, along with dysesthesias into the upper extremities bilaterally. Testing today is to rule out an upper extremity peripheral neuropathy versus a cervical radiculopathy."

   Per the ODG, nerve conduction studies of the neck and upper back are "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) See also the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective."

   The ODG states nerve conduction studies of the shoulder are "Recommended as indicated below. Electrodiagnostic testing is reliable for the diagnosis of TOS. It helps localize and quantify a lesion in the brachial plexus. It is also important to rule out other segmental or systemic neuropathies. Thoracic outlet syndrome (TOS) refers to compression of the neurovascular structures at the superior aperture of the thorax. It represents a constellation of symptoms. The cause, diagnosis, and treatment are controversial. In most cases, the physical examination findings are completely normal. Other times, the examination is difficult because the patient may guard the extremity and exhibit giveaway-type weakness."

   The Division notes that Dr. Wolinsky's report does not refer to the condition referred to in the ODG. Therefore, preauthorization was required per 28 Texas Administrative Code § 134.600(p)(12).

2. According to the explanation of benefits, CPT codes 95900, 95904, 95903 and 95861 were denied reimbursement based upon reason code "225-The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information"; and "CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code)".

   A review of the submitted documentation indicates that the March 11, 2011 nerve studies interpretation report was signed by Joel S. Wolinsky, MD from Physicians Data LLC.

   The March 11, 2011 NeuroDynamics report is unsigned and does not identify the healthcare provider that performed the testing.

   A review of the submitted medical bill indicates that Cary Davis DC billed for the whole procedure. The documentation does not support that Dr. Davis performed the whole procedure for the disputed services. Therefore, the documentation does not support the level of service billed. As a result, reimbursement is not recommended.

3. The respondent denied reimbursement for HCPCS codes A4556, A4215 and A4558 based upon reason codes

"CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; and "217-The value of this procedure is included in the value of another procedure performed on this date".

Per Medicare rules HCPCS codes A4556 and A4558 are bundled codes and payment allowance is included in another service; therefore, reimbursement is not recommended.

Per Medicare rules HCPCS code A4215 is not covered by Medicare in any payment system; therefore, reimbursement is not recommended.

4. According to the explanation of benefits the respondent denied reimbursement for the office visit, CPT code 99211, based upon reason codes "CAC-16-Claim/service lacks information which is needed for adjudication. At least one remark code must be provided (may be comprised or either the remittance advice remark code or NCPDP reject reason code)"; "CAC-97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated"; "857-Modifier-25 billed. Documentation does not support a significant, separately identifiable E&M service"; and "CAC-W1-Workers' compensation state fee schedule adjustment".

   Dr. Davis appended modifier 25 to code 99211 to identify a significant, separate evaluation and management service.

   Modifier 25 is defined as "It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service."

   A review of the submitted documentation finds that Dr. Davis did not submit a copy of the office visit report to support billing of CPT code 99211-25; therefore, the documentation does not support a significant, separate evaluation and management service. As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | 7/9/2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO APPEAL*

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.